CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE
BOARD OF MEDICAL LICENSURE AND DISCIPLINE

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV
EMAIL: customerservice.dpr@state.de.us

APPLICATION FOR PHYSICIAN LICENSE TO PRACTICE MEDICINE
INSTRUCTION SHEET

Please read these instructions carefully. Failing to follow instructions may delay your licensure.

Guidelines for Submitting Your Application Packet

As the applicant, you are responsible for submitting a *complete* application packet to the Board office. We will not process your application until we receive all required items as explained on the checklist below. If your application packet is not complete within three months of filing, we will consider it abandoned and discard your application form and other documents received.

Obtain the required items listed below from the third party sources and submit them all together in a ***single packet*** to the Board office ***unless*** the instructions state that the third party sources will send the items directly to the Board office. When enclosing items from third party sources in your packet, send

- **originals** – not copies – of the items
- **envelopes** in which you received the items

Requirements for *All* Applicants

Your application packet must include all of the following:

☐ Enclose this instruction sheet with the applicable checklists completed.

☐ Submit completed, signed and notarized *Application for Physician License to Practice Medicine* form.
- Make sure all questions are answered unless the instructions tell you to skip a question.
- Read the AFFIDAVIT section.
- Sign the application in front of a notary public.

☐ Enclose processing fee by check or money order made payable to "State of Delaware."

☐ If you *ever* held a medical or training license in any jurisdiction other than Delaware, a license verification from *each* jurisdiction where you have held a license is required. However, you will submit some verifications in your application packet, while others will come directly from the jurisdiction to the Board office. ***Read the following information about requesting verifications carefully:***
- If a jurisdiction utilizes VeriDoc to process license verifications, you must request the verification from VeriDoc, not from the jurisdiction. VeriDoc will send the verification directly to the Board office, not to you. For a list, click VeriDoc Participating States.
- If you have ever held an Indiana license, request a digitally certified verification at http://www.in.gov/pla/verify.htm. The site will download a verification in pdf format to your computer. Print the pdf document and send it in your packet. Contrary to the instruction on Indiana's site, please do *not* email the pdf document to the Board office unless the Board office asks you to do so.
- For all other jurisdictions, request the jurisdiction to send the verification to you and include it in your packet.
  - You may use the *Verification of Physician License* form included with this application form to request the verification.
  - You may wish to obtain an AMA Profile or AOA Profile in order to make sure that you request verifications of all licenses that you have ever held.
  - Before requesting a verification, check whether the jurisdiction requires a fee.
  - The jurisdiction's seal must be affixed to the form.
  - Remember to enclose the envelope in which you received the verification from the third party source.
- Verifications that you print off the internet or receive by fax will not be accepted.

☐ Unless an exception listed below applies, obtain a *Service Letter* from *each* healthcare facility where you currently have, or had within the past five years, either direct patient access or admitting or staff privileges.
- ***A responsible physician at the facility must sign the form.***
- Remember to enclose the envelopes in which you received each *Service Letter*.
- You do ***not*** have to provide a *Service Letter* for the following practice situations:
  - You were practicing as an intern, resident, fellow, or house physician for the past five years.
  - Your practice for the past five years was via telemedicine *with no direct patient access*.
  - You were a *locum tenens with no direct patient access* for the past five years.

☐ If any of the following describes your situation, obtain *two* letters of reference from physicians who are familiar with you but are not related to you:
- You were self-employed for the entire past five years, or
- You had ***no*** direct patient access during the past five years, or
- One or more of the facilities where you had direct patient access in the past five years no longer exists.

☐ If you answer "yes" to questions in the DISCLOSURES section – other than Questions 32, 34, 35 – you must fully explain your answer. We suggest that you use the *Physician Self-Report* form for this purpose. However, if the *Physician Self-Report* does not fully cover your situation, submit a *signed, notarized statement* in lieu of or in addition to the *Physician Self-Report*.

☐ Request a self-query from the National Practitioner and Healthcare Integrity and Protection Data Banks (NPDB/HIPDB) website at www.npdb-hipdb.hrsa.gov. The self-query report will be mailed to your address. When you receive the report, enclose the ***original report*** in your application packet.

☐ If you have never been issued a U.S. Social Security Number (SSN), complete a *Request for Exemption from Social Security Number Requirement*.
- *The Privacy Act of 1974, Section 7, requires the following information to be given to all applicants:* Applicants for any Delaware professional or occupational license, permit, registration or certificate (other than Gaming permits) are required to provide a U.S. SSN (29 *Del. C.* §8735(m)). The Division of Professional Regulation uses the SSN primarily to verify identity and safeguard personal information. It may also be used to enforce child support obligation (13 *Del. C.* §2216) and for other lawful purposes.

In addition, arrange for the Board office to receive the following documents directly from the third party sources.

☐ Complete the *Criminal History Record Check Authorization* form to request State of Delaware and Federal Bureau of Investigation criminal background checks. Follow the instructions on the authorization form to arrange to be fingerprinted. *The State Bureau of Identification will send the report directly to the Board office.*
Date requested: _____

☐ Complete, sign and submit the *Delaware Child Protection Registry Request Form* to the Department of Services for Children, Youth & Their Families (DSCYF) following the instructions on the form. *DSCYF will send the report directly to the Board office.*
Date requested: _____

☐ If a jurisdiction where you have ever held a medical or training license utilizes VeriDoc to process their license verifications, request the verification from VeriDoc, not from the jurisdiction. VeriDoc *will send the verification directly to the Board office*. For a list, click VeriDoc Participating States.
Date requested: _____

Additional Requirement for *FCVS Applicants*

Delaware accepts the Federation Credentials Verification Service (FCVS) of the Federation of State Medical Boards (FSMB). If you are using the FCVS service, the following requirement applies in addition to the items listed in **Requirements for All Applications** above:

☐ Request your Physician Information Profile from FCVS at www.fsmb.org/fcvs_physician.html. *FCVS will send the profile directly to the Board office*.
Date requested: _____

Additional Requirements for *Non-FCVS Applicants*

If you are *not* using the FCVS service, the application packet that you submit must include all of the following in addition to the items listed in **Requirements for All Applications** above:

☐ Submit an 8 1/2" X 11" copy of your medical school diploma.
- If you are a foreign medical graduate, attach an English translation from a reputable translating organization.

☐ Obtain a *Verification of Medical Education* from *each* medical school you attended.
- The school's seal must be affixed to the form. If no seal is available, the form must be notarized.
- Internet verifications or faxed verifications will not be accepted.

☐ If you graduated from a foreign medical school, submit 8 1/2" X 11" copy of your current and valid Educational Commission for Foreign Medical Graduates (ECFMG) certificate.

☐ Submit an 8 1/2" X 11" copy of your Postgraduate Education Training Certificate(s).
- Only training programs are those that have been approved by the Accreditation Council for Graduate Medical Education will be accepted.
- If you graduated from a program approved by the American Medical Association (AMA) or American Osteopathic Association (AOA) in the U.S. (or U.S. territory) or Canada, you must have completed one year of postgraduate training in the U.S.
- If you did not graduate from an AMA- or AOA-approved program, you must have completed three years of postgraduate training in the U.S.

☐ Obtain a *Verification of Post Graduate Medical Education* form from *each* program that you attended.
- The program's seal must be affixed to the form. If no seal is available, the form must be notarized.
- Internet verifications or faxed verifications will not be accepted.

☐ Obtain a complete examination history, including all passing and failing attempts, from the following organizations:
- ECFMG – Request report at www.ecfmg.org.
- Federal Licensing Examination (FLEX), United States Medical Licensing Examination (USMLE), and Special Purpose Examination (SPEX) examinations administered by the Federation of State Medical Boards – Request report at www.fsmb.org.
- National Board of Medical Examiners (NBME) examination administered by the National Board of Medical Examiners – Request report at www.nbme.org.
- National Board of Osteopathic Medical Examiners (NBOME) Comprehensive Osteopathic Medical Licensing Examination (COMLEX-USA) examinations administered by the National Board of Osteopathic Medical Examiners. Request report at www.nbome.org
- Qualifying Examination (QE) Part I and Part II conducted by the Medical Council of Canada for the purpose of awarding the "Licentiate of the Medical Council of Canada" (LMCC). Request report at www.mcc.ca.

Controlled Substance Registration

- **The application for Physician licensure is NOT an application for a controlled substance registration (CSR). For the CSR application and instructions, see *Application for Controlled Substances Registration – Practitioners*.**

- If you apply for your Physician license and CSR at the same time, the Controlled Substance application will be processed *after* your Physician license is issued. When your Delaware CSR is approved, you must then file for a federal DEA registration.

- Delaware law prohibits, with few exceptions, prescribing of controlled substances to patients in Delaware via the internet or telemedicine. You may contact the Office of Controlled Substances if you wish to discuss this matter.

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APPLICATION FOR PHYSICIAN LICENSE TO PRACTICE MEDICINE

TYPE OF APPLICATION

1. I am applying for Physician licensure as a:

   ☐ MD – I received my medical education: ☐ in the U.S. ☐ outside the U.S.

   ☐ DO

2. **Will you use the FCVS to provide your Physician Information Profile to the Board? Yes ☐ No ☐**

IDENTIFYING AND CONTACT INFORMATION

3. Full Name: _____ _____ _____
   Last/Family First Middle

4. Other Names Used: _____ _____ _____

5. Date of Birth (month/day/year): _____ Gender: Male ☐ Female ☐

6. Do you have a U.S. Social Security Number? Yes ☐ No ☐ If yes, enter your SSN: _____
   If no, you must file a *Request for Exemption from Social Security Number Requirement*.

7. Mailing Address: _____

   _____ _____ _____
   City State Zip

8. Phone: _____ _____ Email: _____
   Home Work

MEDICAL EDUCATION

9. Enter complete information about your medical education.

SCHOOL NAME	LOCATION	DATES ATTENDED	DEGREE RECEIVED

If you are <u>not</u> using FCVS, submit an 8 1/2" X 11" copy of your medical school diploma and a *Verification of Medical Education* form from each medical school.

10. Did you graduate from a foreign medical school? Yes ☐ No ☐ If yes, enter your USMLE/ECFMG Identification Number: 0- _____ **If you are <u>not</u> using FCVS, submit 8 1/2" X 11" copy of your ECFMG certificate.**

POST-GRADUATE TRAINING

11. Enter **complete** information about all your post-graduate training, to include fellowships or specialty trainings. **If you need more room, enclose a separate sheet with the same information.**

HOSPITAL/INSTITUTION	LOCATION	DATES OF TRAINING	SPECIALTY

If you are <u>not</u> using FCVS, submit an 8 1/2" X 11" copy of your Postgraduate Education Training Certificate(s) and a *Verification of Post Graduate Medical Education* form from *each* program.

12. Enter information about your area/field of specialization.

AREA/FIELD	ARE YOU BOARD ELIGIBLE?	ARE YOU BOARD CERTIFIED?
	Yes ☐ No ☐	Yes ☐ No ☐
	Yes ☐ No ☐	Yes ☐ No ☐
	Yes ☐ No ☐	Yes ☐ No ☐

EXAMINATION HISTORY

13. Check each examination that you have taken and enter the requested information about that exam.

☐ ECFMG (Basic) If passed, date: _____
☐ ECFMG (Clinical) If passed, date: _____
☐ ECFMG (English) If passed, date: _____

☐ Flex Component 1 If passed, date: _____
☐ Flex Component 2 If passed, date: _____
☐ Pre-1985 Flex If passed, date: _____

☐ USMLE Step 1 If passed, date: _____
☐ USMLE Step 2 If passed, date: _____
☐ USMLE Step 3 If passed, date: _____

☐ NBME Part 1 If passed, date: _____
☐ NBME Part 2 If passed, date: _____
☐ NBME Part 3 If passed, date: _____

☐ NBOME Part 1 If passed, date: _____
☐ NBOME Part 2 If passed, date: _____
☐ NBOME Part 3 If passed, date: _____

☐ SPEX If passed, date: _____

☐ COMLEX Level 1 If passed, date: _____
☐ COMLEX Level 2 If passed, date: _____
☐ COMLEX Level 3 If passed, date: _____

☐ LMCC If passed, date: _____
☐ State Board Examination State: _____ If passed, date: _____

If you are <u>not</u> using FCVS, submit complete examination histories, including all passing and failing attempts, from the organization.

LICENSURE HISTORY

14. Have you ever held a medical license issued by another jurisdiction (state, U.S. territory or District of Columbia)? Yes ☐ No ☐ If yes, list *each* jurisdiction where you now hold, or have *ever* held, a medical license, including training licenses. If you need more room, enclose an additional sheet with the same information.

JURISDICTION	LICENSE NUMBER	ISSUE DATE	EXPIRATION DATE

A license verification from *each* jurisdiction where you have held a license is required. This applies whether or not you are using FCVS. *See the Instruction Sheet for details on how to submit license verifications.*

PRACTICE HISTORY

15. Have you ever practiced medicine other than as an intern, resident, fellow or house physician? Yes ☐ No ☐ **If yes, continue with the next question. If no, obtain *two* letters of reference from physicians who are familiar with you but are not related to you AND skip to the DISCLOSURES section.**

16. During the past five years, have you practiced medicine ***only*** as a *locum tenums* with no direct patient access or ***only*** via telemedicine with no direct patient access? Yes ☐ No ☐ **If yes, obtain *two* letters of reference from physicians who are familiar with you but are not related to you AND skip to the DISCLOSURES section.**

17. Did you have any direct patient access during the past five years? Yes ☐ No ☐ **If no, obtain *two* letters of reference from physicians who are familiar with you but are not related to you AND skip to the DISCLOSURES section.**

18. Were you self-employed for the entire past five years? Yes ☐ No ☐ **If yes, obtain *two* letters of reference from physicians who are familiar with you but are not related to you AND skip to the DISCLOSURES section.**

19. List ***each*** healthcare facility where you currently have, **or** had within the past five years, either direct patient access or admitting or staff privileges. *If you need more room, enclose a separate sheet with the same information.*

FACILITY NAME	ADDRESS	AFFILIATION DATES		DOES THIS FACILITY STILL EXIST?
		From	To	
				Yes ☐ No ☐
				Yes ☐ No ☐
				Yes ☐ No ☐
				Yes ☐ No ☐
				Yes ☐ No ☐
				Yes ☐ No ☐
				Yes ☐ No ☐
				Yes ☐ No ☐
				Yes ☐ No ☐

Obtain a *Service Letter* from *each* listed healthcare facility that still exists. In addition, if any of the listed facilities no longer exists, obtain *two* letters of reference from physicians who are familiar with you but are not related to you.

DISCLOSURES

If you answer "yes" to questions in this section – other than Questions 32, 34, 35 – you must fully explain your answer. We suggest that you use the *Physician Self-Report* form for this purpose. However, if the *Physician Self-Report* does not fully cover your situation, submit a signed, notarized statement in lieu of or in addition the *Physician Self-Report*. Specify the jurisdiction where the incident occurred, the issues involved and any further information you wish to provide.

20. Have you ever been convicted of or entered a plea of guilty or *nolo contendere* (no contest) to any felony, misdemeanor or any other criminal offense in any jurisdiction, including any offense for which you have received a pardon? Yes ☐ No ☐

    Arrange for the Board office to receive State of Delaware and Federal Bureau of Investigation criminal background checks. The State Bureau of Identification will send the reports directly to the Board office. This requirement applies whether or not you are using FCVS.

21. Have you ever been professionally penalized or convicted of fraud? Yes ☐ No ☐

22. Have you ever had a medical or professional license denied or revoked? Yes ☐ No ☐

23. Have you ever violated the Medical Practice Act of another jurisdiction? Yes ☐ No ☐

24. Have you ever been disciplined or had formal written action taken by a hospital staff or medical society, or licensing board of another jurisdiction? ***Your response should include any discipline or action taken during your training program including, but not limited to, academic probation.*** Yes ☐ No ☐

    Request a self-query from the NPDB/HIPDB. When you receive the report, enclose the *original report* in your application packet. This applies whether or not you are using FCVS.

25. Has a hospital, related health care facility, HMO, or alternative health care system ever:
    - denied your application for privileges or failed to renew your privileges? Yes ☐ No ☐
    - limited, restricted, suspended, or revoked your privileges in any way (including during your training program)? Yes ☐ No ☐

26. Have you ever been the subject of an investigation by a licensing authority, medical association, hospital or other healthcare institution? Yes ☐ No ☐ **If yes, provide a copy of any documents in your possession related to the final disposition of the investigation and continue with the next question. *If no, skip to Question 28*.**

27. Do you agree to sign an authorization for the Board of Medical Licensure and Discipline and the Division of Professional Regulation to obtain any and all information concerning the disposition of the investigation directly from the licensing authority, medical association, hospital or other healthcare institution? Yes ☐ No ☐

28. Have any charges or complaints of any kind, including criminal charges and malpractice claims, ever been filed against you? (Include any that are *currently* pending against you.) Yes ☐ No ☐

29. Have you ever engaged in the practice of medicine without a license? Yes ☐ No ☐

30. Have you ever willfully violated the confidence of a patient? Yes ☐ No ☐

31. Within the past five years, have you ever raised the issue of consumption of drugs or alcohol or the issue of a mental, emotional, nervous, or behavioral disorder or condition as a defense, mitigation, or explanation for your actions in the course of any of the following:
    - administrative or judicial proceedings or investigation? Yes ☐ No ☐
    - inquiry or other proceeding? Yes ☐ No ☐
    - proposed termination by an educational institution, employer, governmental agency, professional organization, or licensing authority? Yes ☐ No ☐

    If yes to ***any*** item, continue with the next question. **If no to *all*, skip to Question 33.**

32. Are such current conditions or impairments reduced or ameliorated because of ongoing treatment (with or without medication) or participation in a monitoring program or because of the field of practice, the setting, or the manner in which you have chosen to practice medicine? Yes ☐ No ☐

33. Do you have a mental or physical disability that limits your ability to practice medicine in a fully competent and professional manner with safety to patients? Yes ☐ No ☐ **If yes, continue with the next question. If no, skip to Question 35.**

34. Are you willing to accept a conditional or limited license to practice medicine if it is possible to accommodate such disability? Yes ☐ No ☐

35. Do you agree to submit to an examination at your own expense if the Executive Director of the Board of Medical Licensure and Discipline deems it necessary to determine whether your physical and/or mental impairment presents a significant risk to the health or safety of patients or otherwise causes you not to be fully qualified to practice medicine in a competent and professional manner with safety to patients without limitations or accommodations? Yes ☐ No ☐ **If no, submit a signed, notarized statement fully explaining your answer.**

DUTY TO REPORT

36. To obtain a license in Delaware, you must certify that you understand that you have a ***mandatory*** obligation to file a written report with the Board of Medical Licensure and Discipline within 30 days if you have any reason to believe that a medical practitioner *other than yourself* is (or may be) guilty of unprofessional conduct as defined in 24 *Del. C.* §1731 OR that he/she is (or may be):
    - medically incompetent
    - mentally or physically unable to engage safely in the practice of medicine
    - excessively using or abusing drugs including alcohol.

    I certify that I have read and understand the provisions of 24 *Del. C.* §1730, 24 *Del. C.* §1731 and 24 *Del. C.* §1731A and that I understand my *duty to report*. Yes ☐ No ☐

37. To obtain a license in Delaware, you must certify that you understand that you have a ***mandatory*** obligation to make an immediate oral report to the Department of Services for Children, Youth and Their Families if you know of, or you suspect, child abuse or neglect under Chapter 9 of Title 16 and to follow up with any requested written reports.

    I certify that I have read and understand 16 *Del. C.* §903 and that I understand my *duty to report*. Yes ☐ No ☐

38. To obtain a license in Delaware, you must certify that you understand that you have a ***mandatory*** obligation to self report all of the following:
    - Any change in hospital privileges and any disciplinary action taken by any medical society against you within 30 days (24 *Del. C.* §1730(b)(1))
    - Any civil or criminal investigation in any jurisdiction which concerns your certification or license or other authorization to practice medicine within 30 days (24 *Del. C.* §1730(b)(2))
    - All information concerning medical malpractice claims settled or adjudicated to final judgment, as provided in Chapter 68 of Title 18, within 60 days. (24 *Del. C.* §1730 (c))
    - Each final judgment, settlement, or award against you regardless whether you have malpractice insurance, within 30 days of the final judgment, settlement, or award. (24 *Del. C.* §1731A (f))
    - Any reports filed against you with the Department of Services for Children, Youth and Their Families under Chapter 9 of Title 16 concerning child abuse or neglect (24 *Del. C.* §1730 (d))
    - Any reports filed against you to the Division of Long Term Care Residents Protection under Chapter 85 of Title 11 concerning adult abuse, neglect, mistreatment or financial exploitation (24 *Del. C.* §1730 (d))

    I certify that I have read and understand all of provisions in the Delaware Medical Practice Act, including those listed above, and understand my *duty to self report*. Yes ☐ No ☐

    Complete, sign and submit the *Delaware Child Protection Registry Request Form* to the Department of Services for Children, Youth & Their Families (DSCYF) following the instructions on the form. DSCYF will send the report directly to the Board office.

If your application requires Board review, the Board office must receive all of these items no later than 4:30 PM ten full working days before the Board's meeting date:

- **Completed, signed and notarized application form**
- **Fee payment**
- **All required supporting documentation.**

If your application packet is not complete within three months of filing, we will consider it abandoned and discard your application form and all other documents received. When your application packet is <u>complete</u>, please allow 4-8 weeks to receive your license.

AFFIDAVIT

I swear all of the following:

- I am the person who executed this application.
- The statements contained on this application are true in every respect.
- I have not suppressed or withheld information that might affect this application.
- I will abide by the laws and the ethical standards of this profession.
- I have read and understand this statement.

I hereby authorize and consent to have an investigation conducted to determine my professional qualifications, to determine whether I have previously engaged in unprofessional conduct as defined in 24 *Del. C.* §1731 or the Rules and Regulations of the Delaware Board of Medical Licensure and Discipline and to determine that I am physically and mentally capable of engaging in the practice of medicine with safety to the public.

I authorize and request every person, hospital, clinic, community, governmental agency (local, state, federal or foreign), court, association, institution or other organization having control of any documents, records or other information pertaining to me, to furnish to the Delaware Board of Medical Licensure and Discipline any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or other pertinent data and to permit the Delaware Board of Medical Licensure and Discipline or any of its agents or representatives to inspect and make copies of such documents, records, and other information, in connection with this application, subsequent licensure or practice thereunder.

I understand and acknowledge that the Delaware Board of Medical Licensure and Discipline will rely on the information I have provided in this application in making its determination on licensure. I hereby expressly agree to

- Keep the information in this application current until such time as the Board has finally acted on it, and
- Promptly provide any and all additional information requested by or on behalf of the Board.

Signature of Applicant: _____ Date: _____

City of _____ County of _____

Sworn to before me and subscribed in my presence this _____ day of _____, 2_____.

Signature of Notary: _____

SEAL

My Commission Expires: _____

APPLICATIONS THAT ARE UNSIGNED, NOT NOTARIZED, INCOMPLETE OR NOT ACCOMPANIED BY THE REQUIRED FEE WILL BE REJECTED.

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SERVICE LETTER

Instructions to Applicant: Obtain this form from *each* healthcare facility where you currently have, or had within the past five years, either direct patient access or admitting or staff privileges. Submit all forms in your application packet *together with the envelopes in which you received each form*.

Release to be completed by Applicant	Healthcare Facility Name: _____ Address: _____ Applicant Last Name: _____ First: _____ Middle Initial: ____ Other Name(s) Used: _____ Birth Date: _____ **I authorize a full release permitting the Delaware Board of Medical Licensure and Discipline to obtain any and all information pertaining to the facts of my current or previous relationship with this facility**. **Applicant Signature:** _____ Date: _____
Questions to be answered by Responsible Physician **AFFIX OFFICIAL SEAL HERE**	1. **What position did this applicant hold at your facility?** _____ **from** _____/_____/_____ **to** ____/_____/_____ 2. **Was the applicant placed on probation, suspended or in any way sanctioned/disciplined while at your facility? Yes ☐ No ☐** 3. **Was the applicant the subject of an investigation while at your facility? Yes ☐ No ☐** 4. **Did the applicant leave your facility in good standing? Yes ☐ No ☐** 5. **Would you recommend this applicant for privileges or consider rehiring this applicant at your facility? Yes ☐ No ☐** **If you answered "yes" to questions 2 or 3 *or* if you answered "no" to 4 or 5, please attach an explanation.** You may also attach additional comments or information that the Board of Medical Licensure and Discipline should consider prior to determining this applicant's eligibility for licensure. All attachments should be on your facility's letterhead. **A health care facility that fails to make a full and complete disclosure of information shall be subject to a civil penalty of $10,000 for each such violation. Any health care facility providing information about an applicant as required by law shall be immune from claims, suits, liability, damages, or any other recourse, civil or criminal, so long as the person acted in good faith and without gross or wanton negligence. Good faith is presumed until proven otherwise, and gross or wanton negligence must be shown by the complainant. See 24 *Del. C*. §1730(b)(1)c and §1740(b).** I am licensed in the State of _____, License No_____. I have known the applicant personally or professionally for the period ____/ ____/ _____ to _____/ _____/ _____. **Name of Responsible Physician:** _____ **Title:**_____ **Signature of Responsible Physician:** _____ **Date:** _____ **Phone:** _____ **Fax:** _____ **Email:**_____

***Mail* (do not fax) completed, signed and sealed form to the applicant above.**

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VERIFICATION OF PHYSICIAN LICENSE

Instructions to Applicant: You may use this form to obtain a license verification from each jurisdiction where you have ever held a license to practice medicine. Do not use this form for VeriDoc participating jurisdictions or Indiana verifications. Submit all forms in your application packet *together with the envelopes in which you received each form*.

Licensing Authority:_____ Address:_____ City/State/Zip: _____	Applicant Name: _____ Home Address: _____ City/State/Zip: _____

This section to be completed by Applicant	Last Name:_____ First:_____ Middle: _____ SSN:_____ DOB:_____ Other Name(s) Used: _____ License Number(s) in Jurisdiction Named Above: _____ **I am applying for licensure as a Physician in the State of Delaware. Before my application can be reviewed, verification of my license in good standing is required. I am authorizing the release of the information requested on this form to the Delaware Board of Medical Licensure and Discipline.** This includes any medical training licenses. **Applicant Signature:** _____ Date: _____
This section to be completed by Licensing Authority	Our records indicate that the applicant named above was licensed in the State/Province/Jurisdiction of _____ License Number: _____ Issue Date (month/day/year): _____ Expiration Date (month/day/year): _____ Has any discipline activity taken place regarding this licensee? Yes ☐ No ☐ **If yes, please enclose a certified copy of the Board Order with this license verification.**
CERTIFICATION AFFIX OFFICIAL SEAL HERE	**Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct.** **Printed Name of Official:** _____ **Signature of Official:** _____ **Date:** _____ **Title:** _____ **Phone:** _____ **Fax:** _____ **Email:**_____

***Mail* (do not fax) completed, signed and sealed form to the applicant above.**

CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE

BOARD OF MEDICAL LICENSURE AND DISCIPLINE

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV
EMAIL: customerservice.dpr@state.de.us

VERIFICATION OF MEDICAL EDUCATION

Instructions for Applicant: If you are *not* using the FCVS service, obtain this form from each medical school attended. Submit all forms in your application packet *together with the envelopes in which you received each form*.

Educational Institution: _____	Applicant Name: _____
Address: _____	Home Address: _____
City/State/Zip: _____	City/State/Zip: _____

This section to be completed by Applicant

Last Name: _____ First: _____ Middle: _____

SSN: _____ Birth Date: _____

Other Name(s) Used: _____

Applicant Signature: _____ Date: _____

This section to be completed by Institution

1. Enter periods that the applicant named above was enrolled in institution:

YEAR	FROM (month/day/year)	TO (month/day/year)
1		
2		
3		
4		

2. Was the applicant awarded a degree? Yes ☐ No ☐
   - If yes, enter:
     Degree Received: _____ Date Degree Conferred (month/day/year): _____
   - If no, attach explanation of reason applicant did not receive a degree.

AFFIX INSTITUTION OR NOTARY SEAL HERE

I certify that the information above is an accurate account of the applicant's records and is true and correct.

Printed Name of Institution Official: _____

Signature of Official: _____ **Date:** _____

Title: _____

Phone: _____ **Fax:** _____ **Email:** _____

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VERIFICATION OF POST-GRADUATE MEDICAL TRAINING

Instructions for Applicant: If you are *not* using the FCVS service, obtain this form from *each* program attended. Submit all forms in your application packet *together with the envelopes in which you received each form.*

Educational Institution: _____	Affiliated University: _____
Address: _____	Address: _____
City/State/Zip: _____	City/State/Zip: _____

This section to be completed by Applicant

Last Name: _____ First: _____ Middle: _____

SSN: _____ DOB: _____ Other Name(s) Used: _____

Program Participation to be completed by Institution

- Use one section per department. If department is rotating or traditional, provide a schedule of rotations.
- Report Internships, Residencies and Fellowships separately.
- If the PGY is currently underway, report the expected completion date in the TO field.
- Report incomplete PGY's separately from successfully completed PGY's.

PGY Year: _____ ☐ Internship ☐ Residency ☐ Fellowship ☐ Research ☐ Other	Department: _____ From (month/day/year): _____ To (month/day/year): _____ Successfully completed? Yes ☐ No ☐ In Progress ☐ Accreditation: ACGME ☐ AOA ☐ Not Accredited ☐ Other ☐ Explain: _____
PGY Year: _____ ☐ Internship ☐ Residency ☐ Fellowship ☐ Research ☐ Other	Department: _____ From (month/day/year): _____ To(month/day/year): _____ Successfully completed? Yes ☐ No ☐ In Progress ☐ Accreditation: ACGME ☐ AOA ☐ Not Accredited ☐ Other ☐ Explain: _____
PGY Year: _____ ☐ Internship ☐ Residency ☐ Fellowship ☐ Research ☐ Other	Department: _____ From (month/day/year): _____ To(month/day/year): _____ Successfully completed? Yes ☐ No ☐ In Progress ☐ Accreditation: ACGME ☐ AOA ☐ Not Accredited ☐ Other ☐ Explain: _____

Questions to be completed by Institution

1. Did this applicant ever take a leave of absence or break from training? Yes ☐ No ☐
2. Was this applicant ever placed on probation? Yes ☐ No ☐
3. Was this applicant ever disciplined or placed under investigation? Yes ☐ No ☐
4. Did the instructors file any negative reports on this applicant? Yes ☐ No ☐
5. Were any limitations or special restrictions placed on this applicant because of questions of academic incompetence, disciplinary problems or any other reasons? Yes ☐ No ☐

Explain *yes* answers and any other unusual circumstances on a separate sheet.

CERTIFICATION

AFFIX INSTITUTION OR NOTARY SEAL HERE

I certify that the information above is an accurate account of this individual's records and is true and correct.

Print Name of Program Director (MD or DO): _____

Signature of Program Director: _____ **Date:** _____

Phone: _____ **Fax:** _____ **Email:** _____

***Mail* (do not fax) completed, signed and sealed form to the applicant above.**

Revised 2/2014

Instructions for Requesting a Criminal Background Check

Both State of Delaware and Federal Bureau of Investigation criminal background checks are required.

Locations

Kent County – Primary Facility
State Bureau of Identification
Blue Hen Mall & Corporate Center
655 Bay Rd. Suite 1B
Dover, DE 19901
Walk-ins accepted: Mon 9 am – 7 pm, Tue - Fri 9 am – 3 pm
Customer Service: (302) 739-2134

New Castle County - Satellite Facility
State Police Troop Two
100 LaGrange Ave
Newark, DE 19702
(Between Rts. 72 and 896 on Rt. 40)
By appointment only
Scheduling: (302) 739-2528 (local)
(800) 464-4357 (toll free)

Sussex County – Satellite Facility
Delaware State Police Troop Four
South DuPont Hwy & Shortley Rd.
Georgetown DE 19947
(Across from DelDOT & the State Service Ctr.)
By appointment only
Scheduling: (302) 739-2528 (local)
(800) 464-4357 (toll free)

Applicants Residing in Delaware

1. If you are using the New Castle or Sussex Counties locations, call **(800) 464-HELP (4357)** to schedule an appointment. No appointments are needed at the Kent County location.

2. Take the completed *Authorization for Release of Information* form to one of the offices listed above with the fee of $69.00, to cover both the State of Delaware and Federal Bureau of Investigation criminal checks. Money orders and credit cards other than American Express are accepted at all locations. New Castle and Kent Counties accept cash; Sussex County does not accept cash. *Personal checks are not accepted in any county.* As fees are subject to change, contact the agency where you plan to submit your forms for current fees.

Out-of-State Applicants

1. You can be fingerprinted by your local police agency. All types of fingerprint cards are accepted. If your local police agency cannot provide a fingerprint card, call **(302) 739-2134** to request a fingerprint card.

2. Your *Authorization for Release of Information* form and fingerprint card must be complete. If identifying information is missing (such as name, date of birth, race, sex, etc.), your form will be returned.

3. ***Mail*** the *Authorization* form, fingerprint card, and certified check or money order (*personal checks are not accepted*) for $69.00 made payable to "Delaware State Police" to:

Delaware State Police
State Bureau of Identification (SBI)
PO Box 430
Dover, DE 19903-0430

⇨***ALLOW FOUR WEEKS FOR RECEIPT OF RESULTS.***

DO NOT SEND THE FORM OR FEE TO THE BOARD OFFICE

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CRIMINAL HISTORY RECORD CHECK FOR PROFESSIONAL LICENSURE APPLICANTS

AUTHORIZATION FOR RELEASE OF INFORMATION

Please print or type all information in black ink.

Check the type of license for which you are applying:

☐ Adult Entertainment	☐ Mental Health (LPCMH, LCDP, LMFT, LAPCMH, LAMFT)	☐ Psychology
☐ Deadly Weapons Dealer	☐ Nursing (RN, LPN, APN)	☐ Social Work
☐ Dental	☐ Nursing Home Administrator	☐ Real Estate Appraisers
☐ Massage	☐ Pharmacy	☐ Texas Hold'em Individual

☐ Medical (Physicians, Physician Assistants, Respiratory Care Practitioners, Acupuncture Practitioners, Genetic Counselors, Polysomnographers)

Print your current full name:

_____	_____	_____	_____
Last Name	First Name	Middle Initial	Suffix (e.g., Jr., Sr.)

Enter all other names you have used in the past (including, but not limited to, maiden name, former married names, alternative spellings):

1. _____
2. _____
3. _____
4. _____

AUTHORIZATION TO RELEASE INFORMATION

As an applicant, I authorize release of any and all information that you have concerning my **CRIMINAL HISTORY RECORD INFORMATION**. I hereby release you, your organization, the State of Delaware and others from any liability or damage which may result from furnishing this information:

SIGNATURE OF PERSON PRINTED: _____ **Date**: _____

Phone: Home _____ Work _____

Mail the results of my criminal history request to:

Division of Professional Regulation
861 Silver Lake Boulevard, Suite 203
Dover DE 19904
SLC D420A

USE OF CRIMINAL HISTORY RECORD INFORMATION IS RESTRICTED BY LAW AND SHALL BE LIMITED TO THE PURPOSE FOR WHICH IT WAS GIVEN. MISUSE CONSTITUTES A CRIMINAL VIOLATION.

DELAWARE CHILD PROTECTION REGISTRY REQUEST FORM

Fax or Mail Request to:

DSCYF, OCCL
Criminal History Unit
1825 Faulkland Road
Wilmington, DE 19805
Phone: 302-892-5800 Fax: 302-633-5191

When requesting Child Protection Registry checks:

- **Allow 15 working days for results to be processed.**
- **Do not use a cover sheet.**
- **Do not send duplicate requests.**
- **Form must be submitted to DSCYF within 90 days of signature date in order to be processed.**

PART I. APPLICANT INFORMATION – Type or print clearly.

Name: _____ _____ _____
Last First Middle

Other Name(s) Used: _____ _____ _____ DE Drivers License #: _____

Social Security #: _____- ____ - _____ Date of Birth: ___ / ___ / _____ Sex: Male ☐ Female: ☐ Race: _____
mm / dd / yyyy

Address: _____ _____ _____ _____
Street City State Zip

Have you ever been involved in a substantiated case of child abuse or neglect? Yes ☐ No ☐ If Yes, explain:

_____

_____

I hereby authorize The Delaware Department of Services for Children, Youth and Their Families to provide the below named agency/organization with all substantiated cases of child abuse or neglect concerning me contained in the Child Protection Registry. I further release the Delaware Department of Services for Children, Youth and Their Families, its officers and employees from any and all claims arising out of or in any way connected to the release or dissemination of any information concerning me.

Signature: _____ Date: _____

Parent or Guardian Signature if applicant is under the age of 18: _____

PART II. AGENCY/ORGANIZATION INFORMATION

Please check only one:

☐ EDUCATION ☐ HEALTH CARE FACILITY ☐ CHILD CARE ☒ OTHER: State Agency

Agency Identification Number (if applicable): 1179
Requesting Agency Name: **Division of Professional Regulation**
Address: Cannon Building, 861 Silver Lake Boulevard, Suite 203, Dover, DE 19904
Phone: (302) 744-4500 Fax: (302) 739-2711 Contact Person: Nicole Williams

DSCYF USE ONLY

The individual listed above (___ is listed) (___ is NOT listed) on the Delaware Child Protection Registry.

Date: _____ DSCYF Criminal History Unit _____

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EMAIL: customerservice.dpr@state.de.us

PHYSICIAN SELF-REPORT FORM

The Physician's mandatory duty to self-report is in 24 *Del C.* § 1730 and § 1731A. To comply with your duty, complete and submit this form to the Board of Medical Licensure and Discipline within the required time limit. You may duplicate the form.

IDENTIFYING AND CONTACT INFORMATION

1. Physician Name: _____ _____ _____
   Last First Middle
2. Delaware License Number: C ___ - _____
3. Mailing Address: _____

   _____ _____ _____
   City State Zip
4. Office Phone: _____ Email: _____

MALPRACTICE COMPLAINT

5. Plaintiff Name: _____ Age: _____ Sex: _____
6. Address of Record: _____
7. Date of Occurrence: _____
8. Place of Occurrence (office, hospital name & address): _____
9. What was your position in case (e.g., resident, primary physician)? _____
10. Who was the complaint filed against? ☐ Individual Doctor ☐ Group ☐ Hospital
11. Names of other defendant-doctors and/or hospitals: _____

    _____

DISPOSITION

12. What was the disposition? ☐ Verdict ☐ Settled
13. Final Disposition: _____ Date: _____
14. Civil Case No.: _____ Attorney: _____
15. Total Amount Paid (if any): _____
16. Amount Attributable to You: _____
17. Insurance Company Covering You for this Incident: _____

Signature: _____Date: _____

You may attach a detailed explanation of the medical issues involved in the referenced litigation.